Clinical Research Demographic Form

Name: _____ **DOB**: _____/_____/_____
First Middle Last

Address: _____
Street City State Zip

Sex: □ Male □ Female

Primary Telephone Number: _____ - _____ - _____ Type: _____ □ OK to text

Secondary Telephone Number: _____ - _____ - _____ Type: _____ □ OK to text

E-mail Address: _____ □ OK to send e-mails

Preferred Contact Method: □ Phone call □ Text Message □ E-mail

Ethnicity:
□ Hispanic or Latino(a), or of Spanish Origin
□ Not Hispanic or Latino(a) or of Spanish Origin
□ Prefer not to answer

Race (Mark all the apply):
□ Black or African American
□ Asian
□ Native Hawaiian
□ Prefer not to answer
□ American Indian or Alaska Native
□ White
□ Other Pacific Islander
□ Other

Would you like to be considered for future clinical research studies? □ YES □ NO

Select Any of Interest:

□ Blood Test Studies □ Data Collection/Surveys □ Vaccine Studies □ Medication Studies

Patient's Signature: _____ **Date:** _____

EMERALD COAST OB/GYN CLINICAL RESEARCH

103 East 23rd Street, Panama City, FL 32405 | Phone: 850-250-0194| Fax: 850-250-0194

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize Emerald Coast OB/GYN to use and/or disclose the following protected health information:

Records requested from (Facility/Phone/Fax): _____

_____

Records requested to be sent to (Facility/Phone/Fax): _____

_____

For the purpose of (circle one): (1) Continuance of care (2) Insurance (3) Legal (4) Self

(5) Clinical Research Study

Information to be Released:

( ) Office Notes
( ) Lab Results
( ) Radiology Results
( ) Pathology Results
( ) Obstetrical Records
( ) Operative Reports
( ) Cytology
( ) Entire Record
( ) Mammography Images on a disc and paper report
( ) Breast Imaging
( ) Other: _____

This authorization shall be valid for three years from the date signed, at which time this authorization to use or disclose protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at the Facility address. I understand that a revocation is not effective to the extent that the facility has taken action in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. The Facility will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or State Law if it provides greater access rights).
- Refuse to sign this authorization.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital war, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem; HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

********** PLEASE INITIAL BELOW FOR LABS**********

PLEASE INITIAL _____ Yes _____ No — I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.

PLEASE INITIAL _____ Yes _____ No — I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ _____ _____

Signature of Patient or Personal Representative | Date | Patient's Date of Birth

_____ _____

Printed Name of Patient or Personal Representative | Patient's Social Security Number

Received by: _____